CENTRAL ARIZONA REGION ALTERNATE CARE SYSTEM WORKSHOP

January 25-26, 2011 • Wigwam Resort • Litchfield Park, Arizona

Pros & Cons: Alternate Care System Models

There are numerous options for communities to consider when creating an Alternate Care System (ACS). The following is an overview of seven ACS models that have been featured in medical journals as well as example pros and cons.

The list is not intended to be exhaustive, but is presented to provide a springboard for discussion for Central Arizona's healthcare community. The gold stars indicate two models (numbers 6 and 7) that are the focus of the current workshop.

Model Overview	Pros	Cons
Model 1—Overflow Hospital Provides Full Range of Care ▪ Pre-designated facility or facilities that receive disaster victims. ▪ May be an existing healthcare facility or non-healthcare facility. ▪ The facility can be mobile to accommodate patients in locations throughout the community. ▪ Facility serves patients who require inpatient admission as well as other patients.	—Patients receive care in a large, existing facility or mobile facility. —Simplifies patient tracking and surveillance monitoring. —Staffing is simplified as it is limited to one, rather than multiple facilities.	—Providing adequate staffing for a large volume of patients. —Ensuring transportation to and from a single location from throughout Central Arizona. —Equipping a non-medical facility with sufficient medical supplies. —Providing security for the facility.

Model Overview	Pros	Cons
Model 2 Patient Isolation (***for infectious disease outbreak only***) ▪ Infected and non-infected patients are grouped together in a non-healthcare environment, such as a motel or other facility. ▪ This model targets patients who would normally return home from the hospital but cannot because they lack a caregiver or they could potentially spread the illness to a medically vulnerable household member. ▪ Minimal medical care is delivered in Model 2 facilities. ▪ Food and laundry services are provided.	—Limits the spread of infectious disease. —Alleviates the stress on acute healthcare facilities by separating non-critical and critically ill patients.	—Logistically challenging in a large community. —Identifying workable locations. —High cost. —Security concerns. —Providing transportation to and from the facility.
Model 3—Care for Recovering Patients ▪ Acute care hospitals discharge stabilized but less medically needy patients to other ACS facilities. ▪ Receiving ACS facilities serve as "step down" units for patients who are stable but not medically ready for discharge. ▪ Model is similar to the day-to-day business model of hospitals.	—Increases the availability of acute care hospital beds for disaster victims. —Simplifies patient tracking and surveillance monitoring. —Receiving facilities do not require high-level staffing.	—Continuity of care concerns. —Providing sufficient staff for facilities. —Lack of a central location. —Providing transportation to and from facilities.

Model Overview	Pros	Cons
Model 4—Primary Triage & Rapid Patient Screening ▪ Primary patient triage occurs at a non-hospital facility that is located close to a hospital. ▪ Following triage, patients are sent home, to a hospital or to an ACS facility. ▪ Patients are directed to healthcare based on pre-designated and established screening criteria.	—Alleviates stress from acute care hospitals by reserving them for medically needy disaster victims.	—Traffic and security challenges may occur, if the triage facility is located too close to the hospital. —Providing sufficient staff for facilities. —Transportation to and from the triage site.
Model 5—Quarantine ***(only for infectious disease outbreak)*** ▪ People who are asymptomatic—but potentially exposed to an infectious disease—gather in a non-healthcare facility in order to halt the outbreak from spreading.	—Alleviates stress on acute care hospitals by reserving them for the critically ill. —Separates potentially exposed individuals from the general population.	—Challenge of locating a facility to serve the quarantined population. —Logistics (e.g., food, laundry, staffing) at the quarantine facility. —High cost.

Model Overview	Pros	Cons
Model 6—Limited Supportive Care for Non-Critical Patients ▪ Broadening the scope of practice for ambulatory care—community health centers, family care facilities, urgent care centers—allowing them to: ○ deliver IV fluids; ○ hold patients for observation; and ○ administer antibiotics or anti-virals in a fast-track environment. ▪ Triaging patients in a hospital emergency department and then transferring them to ambulatory care sites for services.	—Alleviates stress on acute care facilities. —Expands ability of hospitals to care for critically ill or injured disaster victims. —Requires clinics to modify their scope of practice to deliver certain kinds of services. —Utilizes existing ambulatory care facilities.	—Lack of a central location for delivery of care. —Licensing issues related to ambulatory care centers scope of practice. —Transportation from hospital emergency departments to ambulatory care facilities.
Model 7—Expanded Ambulatory Care ▪ Ambulatory care facilities significantly increase their patient volume by expanding hours and staff to accommodate disaster victims.	—Alleviates stress on acute care facilities by reserving them for the critically ill. —Utilizes existing ambulatory care staff and facilities. —Increases access to care.	—Willingness of ambulatory care centers to participate. —Licensing issues related to increased ambulatory care center hours of operation. —Transportation from hospital emergency departments to ambulatory care facilities.